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CERTIFICATE OF DEATH

AND LAND STATE TO BE FILLED BY THE REGISTRAR

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution and admission) a. STATE <b>Maryland</b> b. COUNTY <b>Valley Lee</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>2 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys</b>		4. DATE OF DEATH <b>Feb. 3, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1900</b>
9. AGE (in years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>	
11. IF UNDER 24 HRS. Hours <b>2</b> Min. <b>59</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry A. Biscoe</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Watts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph Bennett</b>		Address <b>Valley Lee, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal (abdominal) hemorrhage</b> <b>910.5</b> DUE TO (b) <b>Crushing by load of slab wood</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Feb 3 1959</b> Hour <b>12:00</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Valley Lee, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>P. J. Bean</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>P. J. Bean M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Feb 10 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2007

FILE NO.  
100-100000

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Time of Examination	
Place of Examination		Signature of Physician	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Time of Examination	
Place of Examination		Signature of Physician	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2289 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>		CITY <u>Hollywood</u>		CITY <u>Hollywood</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Leonardtown</u>		<u>7 Hrs.</u>		TOWN <u>Hollywood</u>		TOWN <u>Hollywood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Baby Boy Cusic</u>				<u>Feb 3 1959</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Feb. 3 1959</u>	<u>7 yrs.</u>	<u>Months</u>	<u>Days</u>	<u>Hours</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Joseph Cusic</u>				<u>Mary B. Mattingly</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>No</u>		<u>Mary B. Mattingly, Hollywood, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>762.0 IMMEDIATE CAUSE (A) <u>Anoxia Pneumonia adnata</u></u>							
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Anoxia</u></u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>aspiration of fluid (amniotic)</u></u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				<u>YES</u> <input type="checkbox"/> <u>NO</u> <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 3</u>, 19<u>59</u>, to <u>Feb 3</u>, 19<u>59</u>, that I last saw the deceased alive on <u>Feb 3</u>, 19<u>59</u>, and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Michael Barbault</u>				<u>Leonardtown, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>2/6/59</u>		<u>St. John's</u>		<u>Hollywood, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
				<u>W. Clarke Mattingly</u>		<u>Leonardtown, Md.</u>	
<b>DATE</b>							
<u>FEB 10 '59</u>							

2078371XV5

Guthrie &amp; Evans



# CERTIFICATE OF DEATH

1922

DEPT. OF HEALTH

REGISTRATION OF DEATHS

1. NAME OF DECEASED

2. SEX  
3. AGE

4. OCCUPATION

5. PLACE OF BIRTH  
6. DATE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MEDICAL ATTENDANT  
12. SIGNATURE

13. NAME OF DECEASED

14. SEX

15. AGE

16. OCCUPATION

17. PLACE OF BIRTH  
18. DATE OF BIRTH

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF DEATH

22. CAUSE OF DEATH

23. MEDICAL ATTENDANT  
24. SIGNATURE

25. NAME OF DECEASED

26. SEX

27. AGE

28. OCCUPATION

29. PLACE OF BIRTH  
30. DATE OF BIRTH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. CAUSE OF DEATH

35. MEDICAL ATTENDANT  
36. SIGNATURE

37. NAME OF DECEASED

38. SEX

39. AGE

40. OCCUPATION

41. PLACE OF BIRTH  
42. DATE OF BIRTH

43. DATE OF DEATH

44. TIME OF DEATH

45. PLACE OF DEATH

46. CAUSE OF DEATH

47. MEDICAL ATTENDANT  
48. SIGNATURE

49. NAME OF DECEASED

50. SEX

51. AGE

52. OCCUPATION

53. PLACE OF BIRTH  
54. DATE OF BIRTH

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF DEATH

58. CAUSE OF DEATH

59. MEDICAL ATTENDANT  
60. SIGNATURE

61. NAME OF DECEASED

62. SEX

63. AGE

64. OCCUPATION

65. PLACE OF BIRTH  
66. DATE OF BIRTH

67. DATE OF DEATH

68. TIME OF DEATH

69. PLACE OF DEATH

70. CAUSE OF DEATH

71. MEDICAL ATTENDANT  
72. SIGNATURE

73. NAME OF DECEASED

74. SEX

75. AGE

76. OCCUPATION

77. PLACE OF BIRTH  
78. DATE OF BIRTH

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF DEATH

82. CAUSE OF DEATH

83. MEDICAL ATTENDANT  
84. SIGNATURE

85. NAME OF DECEASED

86. SEX

87. AGE

88. OCCUPATION

89. PLACE OF BIRTH  
90. DATE OF BIRTH

91. DATE OF DEATH

92. TIME OF DEATH

93. PLACE OF DEATH

94. CAUSE OF DEATH

95. MEDICAL ATTENDANT  
96. SIGNATURE

97. NAME OF DECEASED

98. SEX

99. AGE

100. OCCUPATION

101. PLACE OF BIRTH  
102. DATE OF BIRTH

103. DATE OF DEATH

104. TIME OF DEATH

105. PLACE OF DEATH

106. CAUSE OF DEATH

107. MEDICAL ATTENDANT  
108. SIGNATURE

109. NAME OF DECEASED

110. SEX

111. AGE

112. OCCUPATION

113. PLACE OF BIRTH  
114. DATE OF BIRTH

115. DATE OF DEATH

116. TIME OF DEATH

117. PLACE OF DEATH

118. CAUSE OF DEATH

119. MEDICAL ATTENDANT  
120. SIGNATURE

121. NAME OF DECEASED

122. SEX

123. AGE

124. OCCUPATION

125. PLACE OF BIRTH  
126. DATE OF BIRTH

127. DATE OF DEATH

128. TIME OF DEATH

129. PLACE OF DEATH

130. CAUSE OF DEATH

131. MEDICAL ATTENDANT  
132. SIGNATURE

133. NAME OF DECEASED

134. SEX

135. AGE

136. OCCUPATION

137. PLACE OF BIRTH  
138. DATE OF BIRTH

139. DATE OF DEATH

140. TIME OF DEATH

141. PLACE OF DEATH

142. CAUSE OF DEATH

143. MEDICAL ATTENDANT  
144. SIGNATURE

145. NAME OF DECEASED

146. SEX

147. AGE

148. OCCUPATION

149. PLACE OF BIRTH  
150. DATE OF BIRTH

151. DATE OF DEATH

152. TIME OF DEATH

153. PLACE OF DEATH

154. CAUSE OF DEATH

155. MEDICAL ATTENDANT  
156. SIGNATURE

157. NAME OF DECEASED

158. SEX

159. AGE

160. OCCUPATION

161. PLACE OF BIRTH  
162. DATE OF BIRTH

163. DATE OF DEATH

164. TIME OF DEATH

165. PLACE OF DEATH

166. CAUSE OF DEATH

167. MEDICAL ATTENDANT  
168. SIGNATURE

169. NAME OF DECEASED

170. SEX

171. AGE

172. OCCUPATION

173. PLACE OF BIRTH  
174. DATE OF BIRTH

175. DATE OF DEATH

176. TIME OF DEATH

177. PLACE OF DEATH

178. CAUSE OF DEATH

179. MEDICAL ATTENDANT  
180. SIGNATURE

181. NAME OF DECEASED

182. SEX

183. AGE

184. OCCUPATION

185. PLACE OF BIRTH  
186. DATE OF BIRTH

187. DATE OF DEATH

188. TIME OF DEATH

189. PLACE OF DEATH

190. CAUSE OF DEATH

191. MEDICAL ATTENDANT  
192. SIGNATURE

193. NAME OF DECEASED

194. SEX

195. AGE

196. OCCUPATION

197. PLACE OF BIRTH  
198. DATE OF BIRTH

199. DATE OF DEATH

200. TIME OF DEATH

201. PLACE OF DEATH

202. CAUSE OF DEATH

203. MEDICAL ATTENDANT  
204. SIGNATURE

205. NAME OF DECEASED

206. SEX

207. AGE

208. OCCUPATION

209. PLACE OF BIRTH  
210. DATE OF BIRTH

211. DATE OF DEATH

212. TIME OF DEATH

213. PLACE OF DEATH

214. CAUSE OF DEATH

215. MEDICAL ATTENDANT  
216. SIGNATURE

217. NAME OF DECEASED

218. SEX

219. AGE

220. OCCUPATION

221. PLACE OF BIRTH  
222. DATE OF BIRTH

223. DATE OF DEATH

224. TIME OF DEATH

225. PLACE OF DEATH

226. CAUSE OF DEATH

227. MEDICAL ATTENDANT  
228. SIGNATURE

229. NAME OF DECEASED

230. SEX

231. AGE

232. OCCUPATION

233. PLACE OF BIRTH  
234. DATE OF BIRTH

235. DATE OF DEATH

236. TIME OF DEATH

237. PLACE OF DEATH

238. CAUSE OF DEATH

239. MEDICAL ATTENDANT  
240. SIGNATURE

241. NAME OF DECEASED

242. SEX

243. AGE

244. OCCUPATION

245. PLACE OF BIRTH  
246. DATE OF BIRTH

247. DATE OF DEATH

248. TIME OF DEATH

249. PLACE OF DEATH

250. CAUSE OF DEATH

251. MEDICAL ATTENDANT  
252. SIGNATURE

253. NAME OF DECEASED

254. SEX

255. AGE

256. OCCUPATION

257. PLACE OF BIRTH  
258. DATE OF BIRTH

259. DATE OF DEATH

260. TIME OF DEATH

261. PLACE OF DEATH

262. CAUSE OF DEATH

263. MEDICAL ATTENDANT  
264. SIGNATURE

265. NAME OF DECEASED

266. SEX

267. AGE

268. OCCUPATION

269. PLACE OF BIRTH  
270. DATE OF BIRTH

271. DATE OF DEATH

272. TIME OF DEATH

273. PLACE OF DEATH

274. CAUSE OF DEATH

275. MEDICAL ATTENDANT  
276. SIGNATURE

277. NAME OF DECEASED

278. SEX

279. AGE

280. OCCUPATION

281. PLACE OF BIRTH  
282. DATE OF BIRTH

283. DATE OF DEATH

284. TIME OF DEATH

285. PLACE OF DEATH

286. CAUSE OF DEATH

287. MEDICAL ATTENDANT  
288. SIGNATURE

289. NAME OF DECEASED

290. SEX

291. AGE

292. OCCUPATION

293. PLACE OF BIRTH  
294. DATE OF BIRTH

295. DATE OF DEATH

296. TIME OF DEATH

297. PLACE OF DEATH

298. CAUSE OF DEATH

299. MEDICAL ATTENDANT  
300. SIGNATURE

301. NAME OF DECEASED

302. SEX

303. AGE

304. OCCUPATION

305. PLACE OF BIRTH  
306. DATE OF BIRTH

307. DATE OF DEATH

308. TIME OF DEATH

309. PLACE OF DEATH

310. CAUSE OF DEATH

311. MEDICAL ATTENDANT  
312. SIGNATURE

313. NAME OF DECEASED

314. SEX

315. AGE

316. OCCUPATION

317. PLACE OF BIRTH  
318.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2290

CERTIFICATE OF DEATH

Reg. Dist. No.

07276

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Cora</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1880</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Mrs. Elizabeth Herbert - Mechanicsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cv disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 24, 1959</b> , to <b>Feb 24, 1959</b> , that I last saw the deceased alive on <b>Feb 24, 1959</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Roy Guyther</b>				ADDRESS (Street, city or town, state) <b>Mechanicsville Md</b> DATE SIGNED <b>2/24/59</b>			
PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, MD</b>				<b>Mechanicsville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Charlotte Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2291

## CERTIFICATE OF DEATH

Reg. Dist. No.

02278

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loveville</u>			
c. LENGTH OF STAY IN 1b <u>176 min.</u>				d. STREET ADDRESS <u></u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bzby Guy</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/59</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>56</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert W. Luy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Robert W. Luy</u>				Address <u>Loveville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercranial hemorrhage</u> <u>760.5</u> DUE TO <u>Precipitous labor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				20g. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>59</u> to <u>Feb 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 AM</u> , 19 <u></u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>2/1/59</u>							
ACTUAL SIGNATURE <u>Leon Berube</u> M.D.				PHYSICIAN'S NAME (Type) <u>Leon Berube M.D.</u> <u>Mechanicsville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) <u>Morganza</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Elaine Mattingly</u> ADDRESS <u>Leonardtown, Md</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

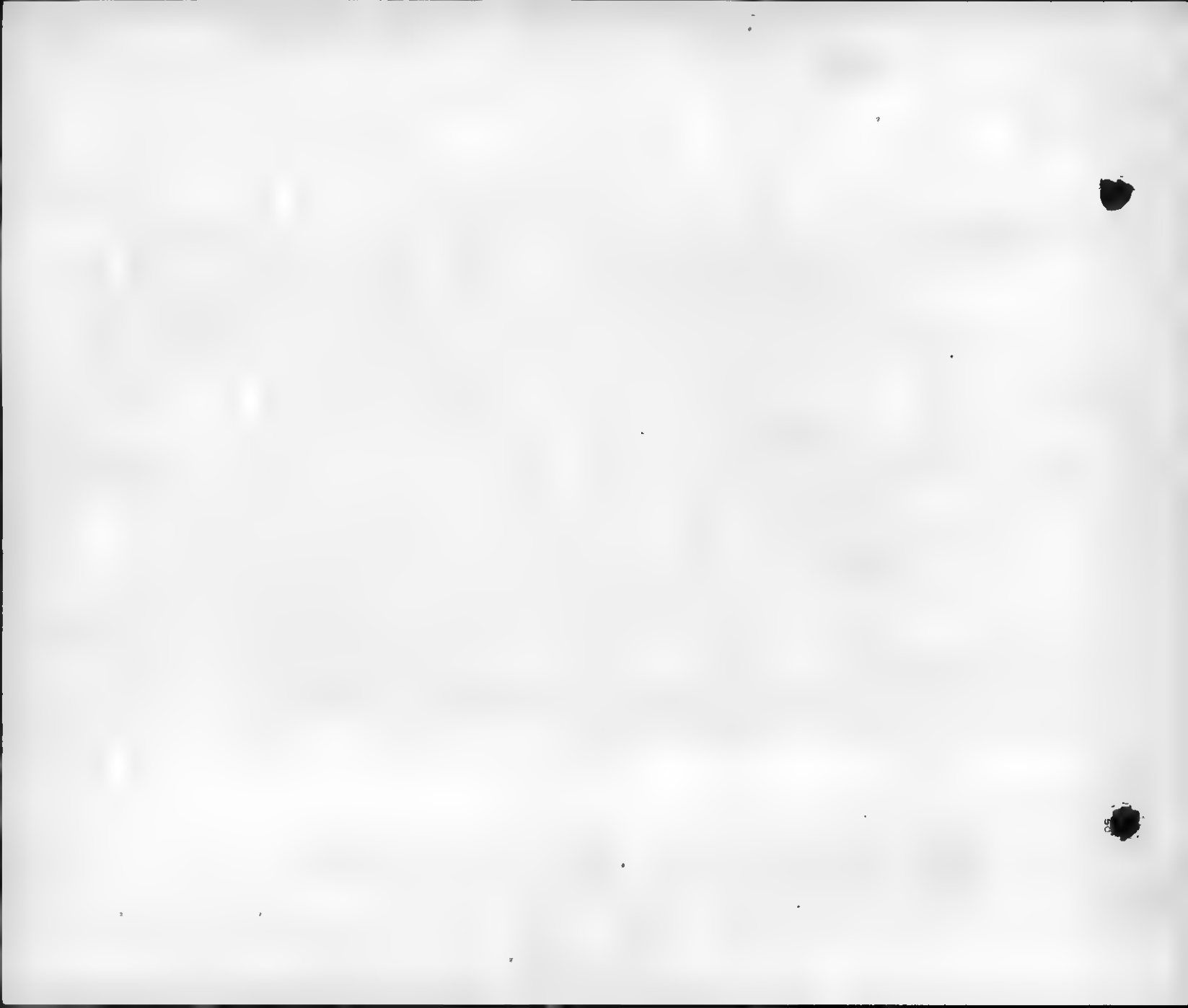
2292

42279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Abell</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Abell</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			f. STREET ADDRESS <b>1</b>		
3. NAME OF DECEASED (Type or print) <b>Edward J. Herman</b>			4. DATE OF DEATH Month <b>2</b> - Day <b>5</b> - Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-1894</b>		9. AGE (in years last birthday) <b>64</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy man</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW12339614220 16 8926</b>		17. INFORMANT <b>World War Service Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>		EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
22d. LOCATION (City, town, or county) (State) <b>Bushwood, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 10 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>		DATE SIGNED <b>2-7-59</b>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2293

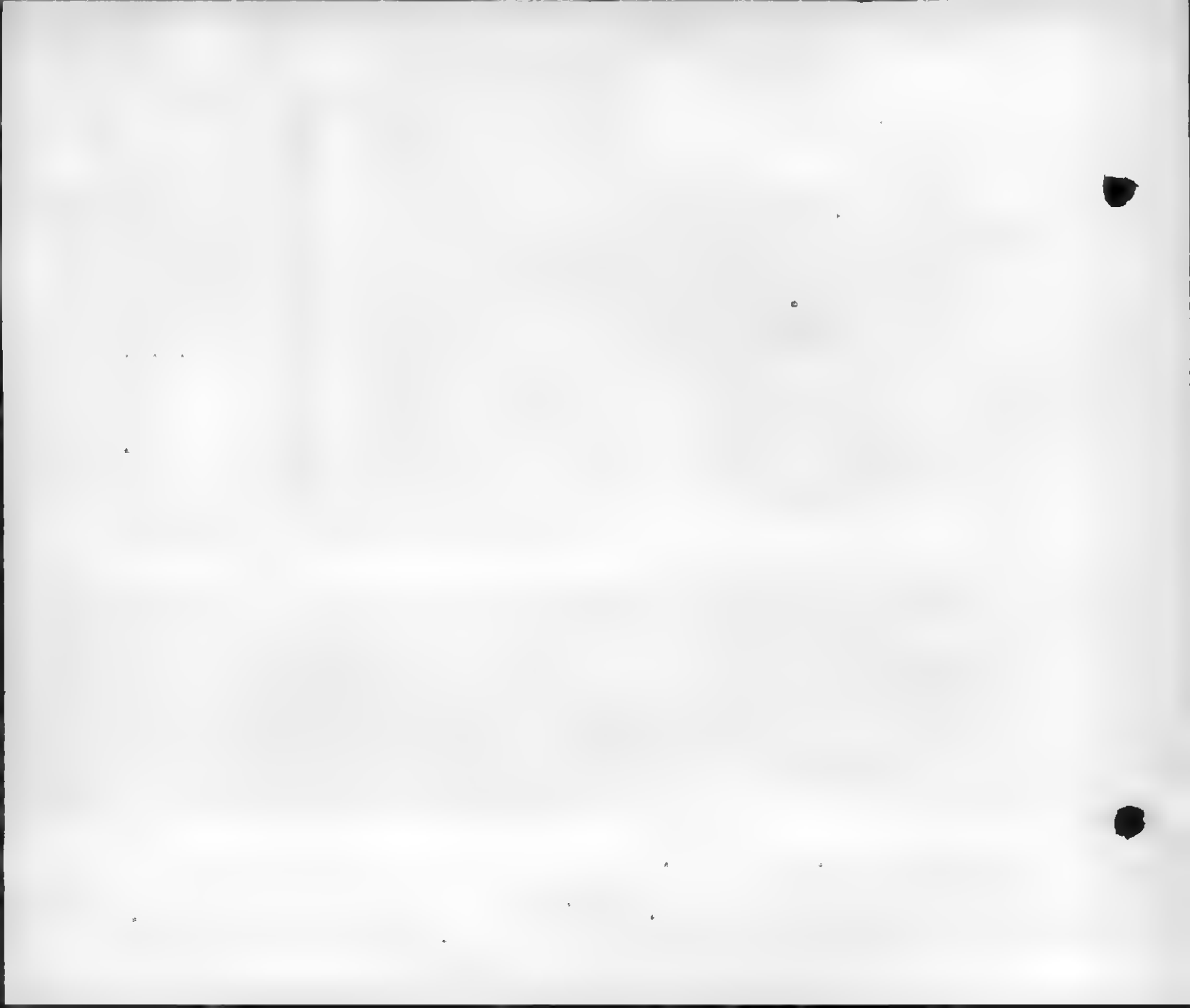
CERTIFICATE OF DEATH

Reg. Dist. No.

02280

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN TB <b>10 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Valley Lee</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Jackson</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>28,</b> Year <b>19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b>
9. AGE (In years last birthday) <b>58</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 -03 9311</b>	
17 INFORMANT <b>Carrie Jackson</b>		Address <b>Valley Lee, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> <b>332</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Streptococcal throat infection.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 18, 1959</b> to <b>Feb 28, 1959</b> , that I last saw the deceased alive on <b>Feb 28, 1959</b> , and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>March 1/59</b>			
ACTUAL SIGNATURE <b>P. J. Bean M. D.</b>		PHYSICIAN'S NAME (Type) <b>Great Mills, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's</b>	22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02281

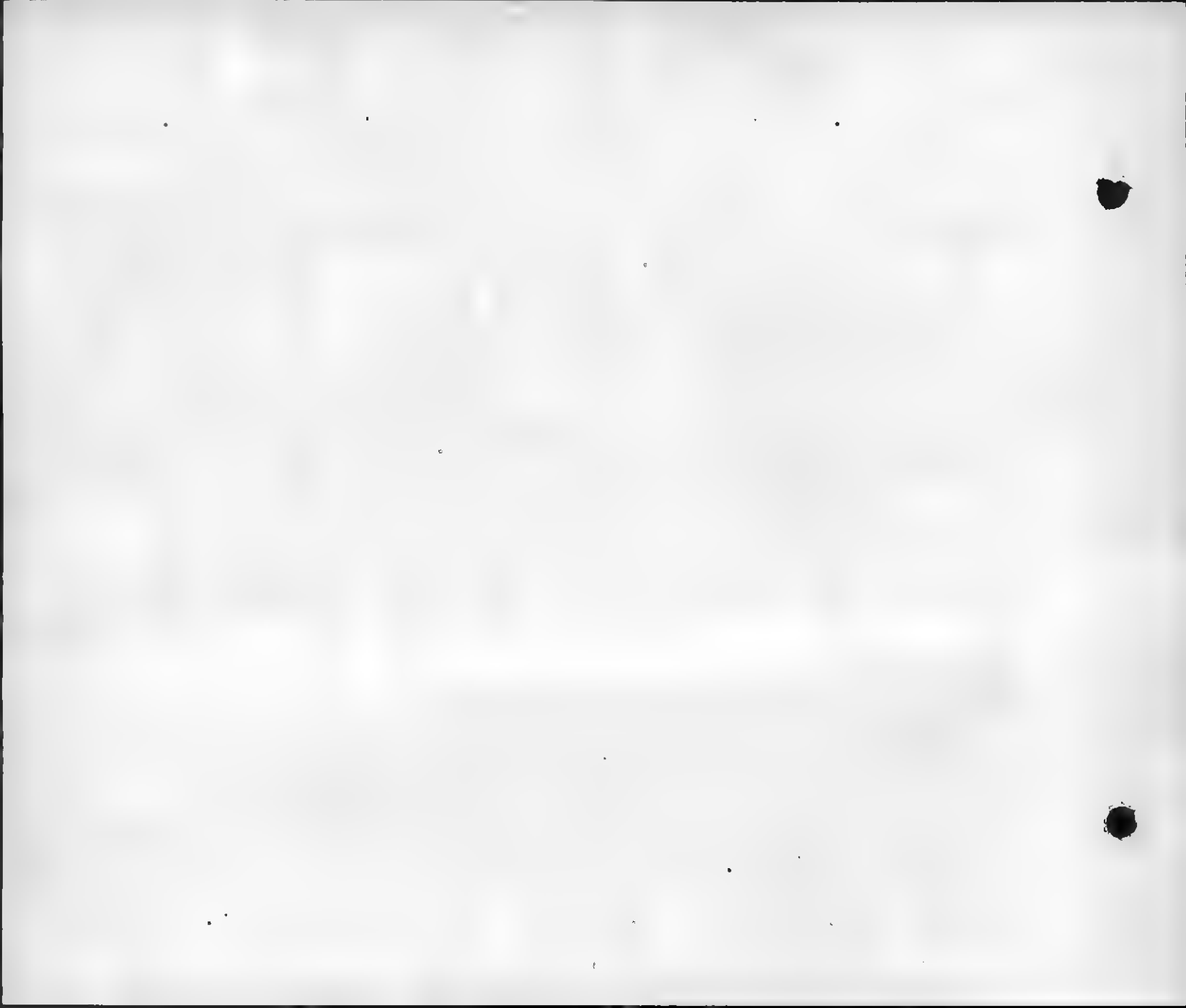
2294

Item 9 film 239 2-24-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scotland</b>		c. LENGTH OF STAY IN 1b <b>5 yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Marys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scotland</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		e. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First		Middle <b>H.</b>		Last <b>Jaminson</b>		4. DATE <b>DEATH</b> <b>Feb. 15</b>		Month		Day		Year <b>19 59</b>							
5. SEX <b>female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1878</b>		9. AGE (In years last birthday) <b>80 31</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Alexander Smith</b>						14. MOTHER'S MAIDEN NAME <b>Lucy Jaminson</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. -----				17. INFORMANT <b>Herman H. Jaminson - Scotland Md.</b>				Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>William D. Boyd</b>				M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>William D. Boyd, MD</b>																DATE SIGNED <b>2/15/59</b>					
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/18/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>				22d. LOCATION (City, town, or county) (State) <b>Scotland, Md.</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>								ADDRESS				24a. REC'D BY REGISTRAR DATE <b>FEB 18 '59</b>				24b. REG STRAR'S SIGNATURE <b>J. S. Kinn</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

Reg. Dist. No.

02282

2295

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. STREET ADDRESS <u>Compton</u>	
3. NAME OF DECEASED (Type or print) <u>Jonathan First Lee Middle Last</u>		4. DATE OF DEATH <u>Feb. 24 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-59</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F</u>		14. MOTHER'S MAIDEN NAME <u>Claudia Lee Bussler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>11.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>premature rupture membranes</u> (c) <u>(Spontaneous)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>59</u> , to <u>2/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>59</u> , and that death occurred at <u>10:55</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Boyd</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2/26/59</u>	
PHYSICIAN'S NAME (Type) <u>William D. Boyd M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>	22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Clifford S. Frank</u>

2078141XVO





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 2296 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

02283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmers Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Palmers</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Thomas Arthur Mattingly</b>		4. DATE OF DEATH <b>Feb. 9, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 15, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water man</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas O. Mattingly</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth L. Goldsborough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Daisy E. Turlington</b>		Address <b>4219-4th. St. S.E. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - 420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis, Diabetic</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/1</b> , 19 <b>57</b> , to <b>Feb 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 8</b> , 19 <b>59</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL <b>Charles Greenwell</b> M.D. <b>Leonardtton</b> PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b> <b>Leonardtton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>FEB 13 '59</b>	
ADDRESS <b>Leonardtton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02281

2297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hollywood</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hollywood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Xavier</u> Last <u>Miedzinski</u>			4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1940</u>		9. AGE (In years (day, month, year)) <u>18</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Joseph M. Miedzinski</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Eva Copsey</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO <u>None</u>			17. INFORMANT <u>Joseph M. Miedzinski</u> Address <u>Hollywood, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u> DUE TO <u>981X</u> (b) <u>immediate</u> (c) <u>981X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>981X</u> (b) <u>981X</u> (c) <u>981X</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Placed shotgun in mouth and pulled trigger</u>					
20c. TIME OF INJURY Month, Day, Year <u>Feb 15 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway near Hollywood St. Mary's Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>P. J. Bean</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>P. J. Bean M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2/18/59</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>			22d. LOCATION (City, town, or county) <u>Hollywood, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>			24a. REC'D BY REGISTRAR <u>Feb 17 1959</u>		
ADDRESS <u>Leonardtwn, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>W. Clarke Mattingley</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2298

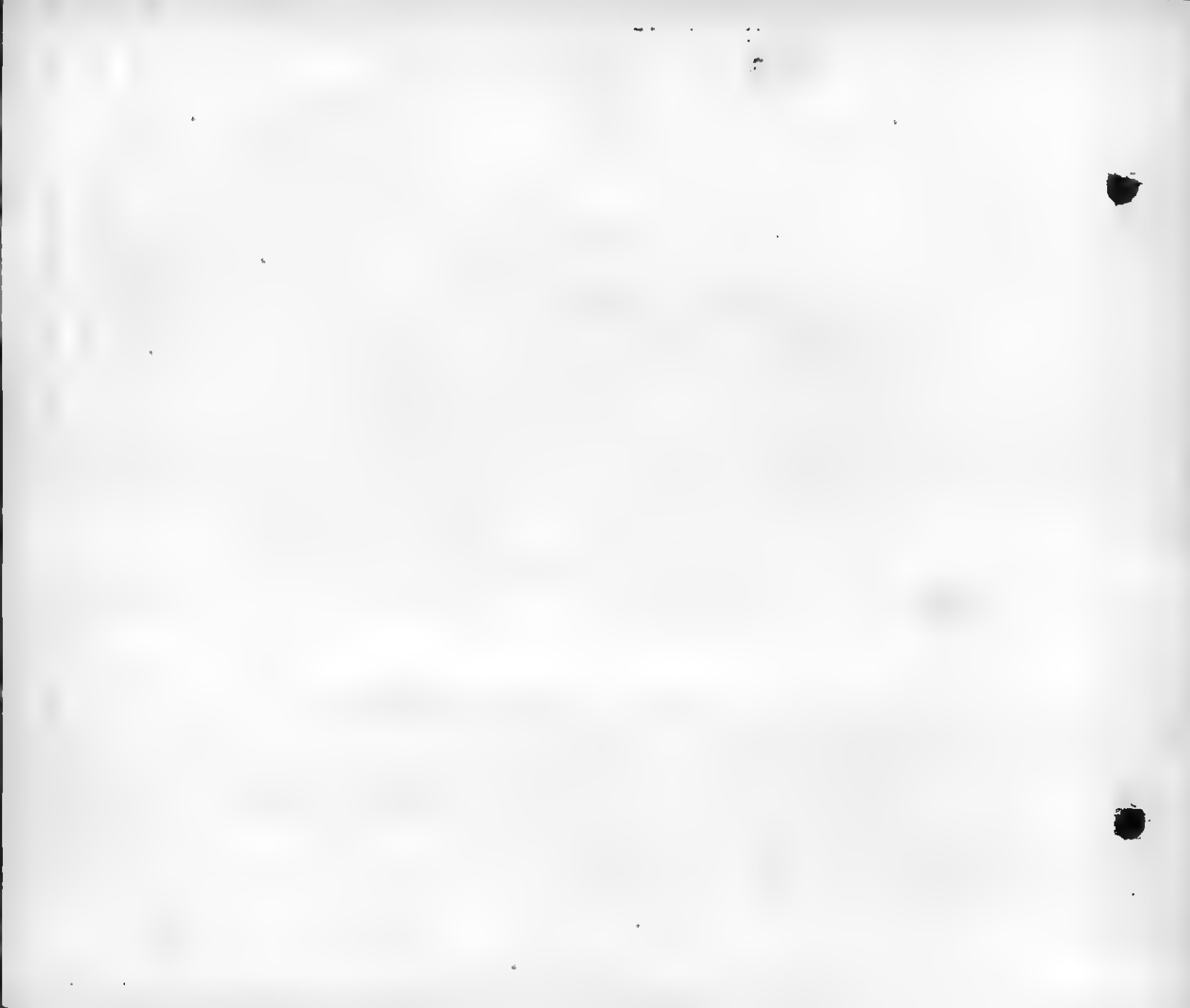
## CERTIFICATE OF DEATH

Reg. Dist. No.

02280

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>2yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Nolan</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1880</b>
9. AGE (In years Last birthday) yrs <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rose Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>John P. Chase</b>		Address <b>Leonardtown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic interstitial Nephritis</b> (c) <b>Cardiac Block</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 Feb 19 59</b> to <b>24 Feb 19 59</b> , that I last saw the deceased alive on <b>16 February 19 59</b> and that death occurred at <b>4:00 P.M. 2/23/59</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Charles Greenwell M. D. Leonardtown, Maryland</b>		DATE SIGNED <b>2/24/59</b>	
ACTUAL SIGNATURE <b>C. Greenwell M. D.</b>		PHYSICIAN'S NAME (Type) <b>Charles Greenwell M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 25 1959</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. Mattingley</b>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2299

## CERTIFICATE OF DEATH

Reg. Dist. No.

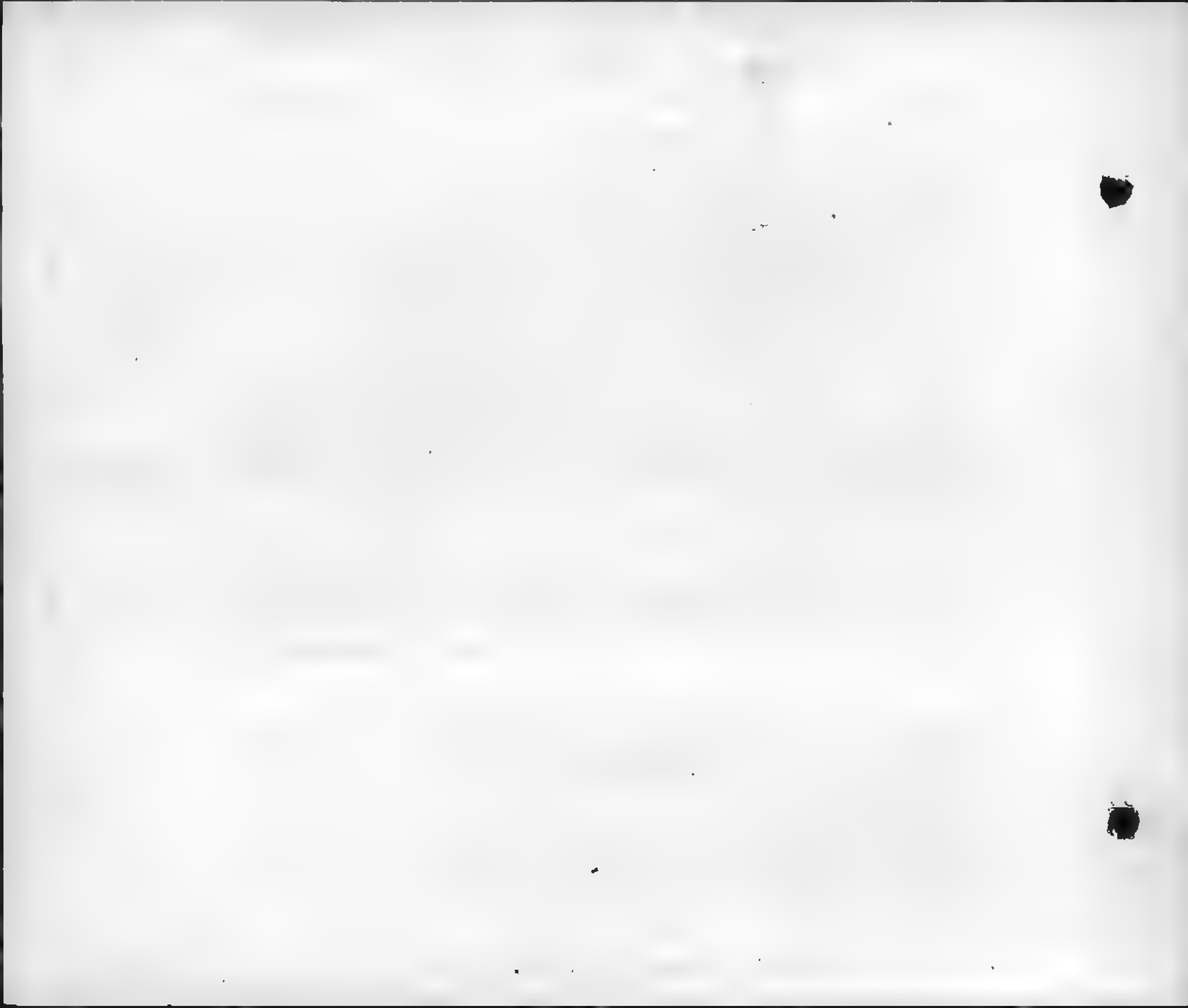
02287

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXX</del> <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>Rural Clements</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Howard</b> Last <b>Raley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John M. Raley</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Farr</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-12-7933</b>		17. INFORMANT <b>Jeanette R. Raley Clements, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/12</b> , 19 <b>57</b> to <b>2-20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/20</b> , 19 <b>59</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtwn, Maryland</b> DATE SIGNED <b>2/21/59</b>			
ACTUAL SIGNATURE <b>W.D. Boyd</b> M.D.		PHYSICIAN'S NAME (Type) <b>William D. Boyd M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>FEB 25 59</b>	
ADDRESS <b>Leonardtwn, Md.</b>		24b. REGISTRAR'S SIGNATURE <b></b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2300

## CERTIFICATE OF DEATH

Reg. Dist. No.

02288

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clements</b> c. LENGTH OF STAY in lb <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Clements</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <b>Wayne</b> First <b>Anthony</b> Middle <b>Russell</b> Last		4. DATE OF DEATH <b>Feb.</b> Month <b>19</b> Day <b>1959</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14. 1890</b> 9. AGE (In years last birthday) <b>68</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Russell</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Herbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs Sarah R. Abell</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary Thrombosis</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 mo.</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1949</b> to <b>Feb 19, 1959</b> that I last saw the deceased alive on <b>Feb 19, 1959</b> and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park, Md</b> DATE SIGNED <b>2-20-59</b>	
PHYSICIAN'S NAME (Type) <b>William H. Patrick M.D.</b>		<b>Lexington Park, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>	22d. LOCATION (City, town, or county) (State) <b>Morganza, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2301

## CERTIFICATE OF DEATH

02290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural California</b> c. LENGTH OF STAY IN IB <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural California</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis S. Toney</b>		4. DATE OF DEATH Month Day Year <b>Feb. 10, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Toney</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Guyther</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>213 22 1561</b>	
17. INFORMANT <b>Martha L. Toney</b>		Address <b>California, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>587.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Pancreatitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>53</b> , to <b>Feb. 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb. 5</b> , 19 <b>59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b>	
DATE SIGNED <b>2-11-59</b>			
PHYSICIAN'S NAME (Type) <b>William H. Patrick M.D.</b>		<b>Lexington Park, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 13 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>	

CERTIFICATE OF DEATH

1911

DECEASED  
NAME

MASSACHUSETTS

Form with multiple lines for recording death details, including fields for name, date, place, and cause of death. The form is mostly blank with some faint, illegible markings.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2302

## CERTIFICATE OF DEATH

Reg. Dist. No.

02291

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>				c. LENGTH OF STAY IN It <b>12 yrs</b>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dossie Henry Wiggins</b>				4. DATE OF DEATH Month Day Year <b>Feb. 18, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1884</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mill</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Wiggins</b>				14. MOTHER'S MAIDEN NAME <b>Jane Osten</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Mabel Jones Box 181 Lexington Park,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>Maryland</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs.</b> 331X DUE TO <b>Cerebral Arteriosclerosis</b> <b>10-15 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 1958</b> , to <b>Feb 18, 1959</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ernest D. Rehm</b> M.D. ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b> DATE SIGNED <b>19 Feb 1959</b> PHYSICIAN'S NAME (Type) <b>Ernest Rehm M. D.</b> <b>Lexington Park, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Youngville, N. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beddingfield Funeral Home Wake Forest,</b> <b>North Carolina</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	



CERTIFICATE OF

8308

WILLIAM BROWN

1871

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